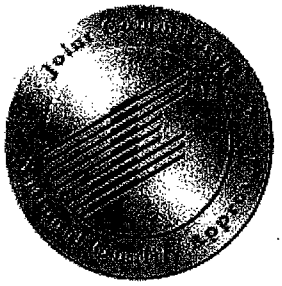
file copy - D. Wardlaw



January 11, 2005

Nikki Morrell
Deputy Director Client Services, Div. of Mental Health
Madison State Hospital
711 Green Road
Madison, IN 47250

Joint Commission ID #: 1136
Accreditation Activity Completed: 12/20/2004
Accreditation Activity: Evidence of Standards Compliance

Dear Ms. Morrell:

The Joint Commission would like to thank your organization for participating in the Joint Commission's accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Hospitals.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that the Joint Commission will keep the report confidential, except as required by law. To ensure that the Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on the Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

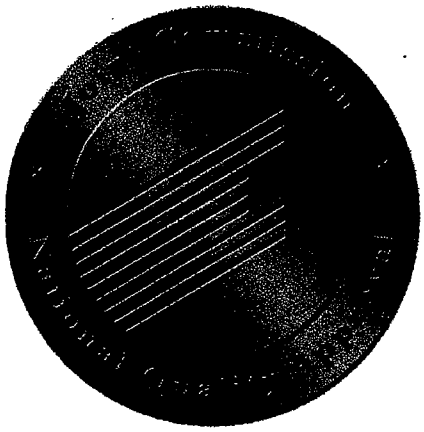
Russell P. Massaro

Russell P. Massaro, MD, FACPE
Executive Vice President
Division of Accreditation Operations

Madison State Hospital

Madison, IN

has been Accredited by the



Joint Commission

on Accreditation of Healthcare Organizations

Which has surveyed this organization and
found it to meet the requirements for accreditation.

2004-2007

Bernard L. Hengesbaugh
Chairman of the Board of Commissioners

Dennis S. O'Leary, M.D.
President

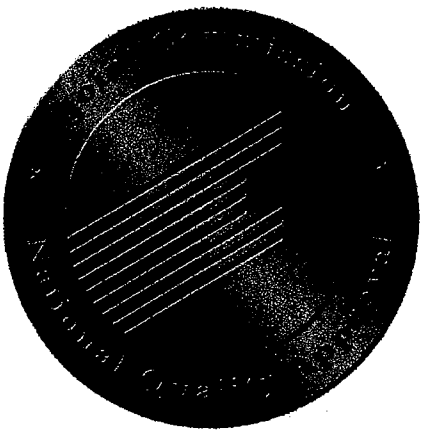
The Joint Commission on Accreditation of Healthcare Organizations is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to the Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through the Joint Commission's web site at www.jcaho.org.

Madison State Hospital

Behavioral Health Care

Madison, IN

has been Accredited by the



Joint Commission

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org: maintenance
cc: Supt. D. Woodfield PI

Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

PEGGY STEPHENS
MADISON STATE HOSPITAL
711 GREEN RD
MADISON IN 47250-2199

September 16, 2005

RE: 711 GREEN RD
15G122
September 13, 2005

Dear PEGGY STEPHENS:

An LSC survey was conducted at your facility by the Division of Long Term Care, Indiana State Department of Health, to determine if your facility was in compliance with Federal requirements for ICF/MR Facilities on September 13, 2005. This survey found your facility to be in compliance with the requirements of the NFPA 101 Life Safety Code.

You will find enclosed a CMS Form 2567L showing that no deficiencies were cited. You may keep this form for your records.

If you have any questions concerning the instructions contained in this letter, please contact:

RICHARD L. POWERS
SUPERVISOR, LIFE SAFETY
DIVISION OF LONG TERM CARE
INDIANA STATE DEPARTMENT OF HEALTH
2 N. MERIDIAN ST., SECTION 4B
INDIANAPOLIS, IN 46204-3003
317/233-7442 FAX: 317/233-7322

Sincerely,

Suzanne Hornstein

SUZANNE HORNSTEIN, MSW
Director
Long Term Care

9/21/05

cc: Public File

Attachment

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
15G122	A. Building B. Wing 02 - ICF-MR REPLACEMENT UNIT	9/13/2005

Name of Facility	Street Address, City, State, Zip Code
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 08/15/2005	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/1/2005

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G122	A. BUILDING 02 B. WING _____	R 09/13/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Life Safety Code and Environmental Preoccupancy Survey for two replacement facilities for a 47 bed ICF/MR (Intermediate Care Facility for the Mentally Retarded) unit completed on 07/19/05, and in accordance with 42 CFR 483.70(j). Survey Date: 09/13/05 Provider Number: 15G122 AIM Number: 100272180 Facility Number: 000659 Surveyor: Mark Bugni, Life Safety Code Specialist Madison State Hospital, which consisted of Building #13, a two story, sprinklered building of Type II (222) construction with a basement, and Building #31, a two story, sprinklered building of Type II (222) construction with a basement, was found to be in compliance with NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) 2000 Edition, Chapter 18, New Health Care Occupancies in regard to the PSR to the Life Safety Code and Environmental Preoccupancy Survey for the 47 bed ICF/MR replacement unit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 09/15/05.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Distr: 8-19-04

G. Barnes
N. Morrell
D. Woodfill
George True
K. Smith
D. Farris

file

Joseph E. Kernan
Governor

Gregory A. Wilson, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

RECEIVED
AUG 19 2004
MADISON STATE HOSPITAL
MADISON, IN 47250

NIKKI MORRELL
MADISON STATE HOSPITAL
711 GREEN RD
MADISON IN 47250-2199

August 13, 2004

RE: 711 GREEN RD
15G122
August 2, 2004

Dear NIKKI MORRELL:

An LSC survey was conducted at your facility by the Division of Long Term Care, Indiana State Department of Health, to determine if your facility was in compliance with Federal requirements for ICF/MR Facilities on August 2, 2004. This survey found your facility to be in compliance with the requirements of the NFPA 101 Life Safety Code.

You will find enclosed a CMS Form 2567L showing that no deficiencies were cited. You may keep this form for your records.

If you have any questions concerning the instructions contained in this letter, please contact:

RICK POWERS
SUPERVISOR, LIFE SAFETY
DIVISION OF LONG TERM CARE
INDIANA STATE DEPARTMENT OF HEALTH
2 N. MERIDIAN ST., SECTION 4B
INDIANAPOLIS, IN 46204-3003
317/233-7442 FAX: 317/233-7322

Sincerely,

Suzanne Hornstein

SUZANNE HORNSTEIN, MSW
Director
Long Term Care

cc: Public File

Attachment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G122	A. BUILDING 01 B. WING _____	8/2/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This visit was a Life Safety Code Recertification Survey, and in accordance with 42 CFR 483.470. Survey Date: 09/02/04 Provider Number: 15G122 AIM Number: 100272180 Facility Number: 000659 Surveyor: Mark Bugni, Life Safety Code Specialist Madison State Hospital, which consisted of the McAtee building, a two story, sprinklered building of Type I(332) construction, with a basement, was in compliance with NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) 2000 Edition, Chapter 19, Existing Health Care Occupancies. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 08/12/04.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Orig to D. Wilson 4.11
cc: Supt

Joseph E. Kernan
Governor

Gregory A. Wilson, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

RECEIVED
NOV 18 2004
MADISON STATE HOSPITAL
MADISON, IN 47250

NIKKI MORRELL
MADISON STATE HOSPITAL
711 GREEN RD
MADISON IN 47250-2199

RE: 711 GREEN RD
15G122

November 16, 2004

Dear NIKKI MORRELL:

A health survey was conducted at your facility by the Division of Long Term Care, Indiana State Department of Health, to determine if your facility was in compliance with Federal requirements for ICFMR facilities on November 15, 2004. This survey found your facility to be in compliance with the requirements of participation described in 42, Part 483 Subpart I and 431 IAC 1.1.

You will find enclosed a CMS Form 2567L showing that no state or federal deficiencies were cited. You may keep this form for your records.

If you have any questions concerning the instructions contained in this letter, please contact:

STEPHEN L. UPCHURCH
ENFORCEMENT MANAGER
DIVISION OF LONG TERM CARE
INDIANA STATE DEPARTMENT OF HEALTH
2 N. MERIDIAN ST., SECTION 4B
INDIANAPOLIS, IN 46204-3003
317/233-7613 FAX: 317/233-7322

Sincerely,

SUZANNE HORNSTEIN, MSW, Director
Long Term Care

cc: Supervisor
Public File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G122	A. BUILDING _____ B. WING _____	R 11/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS Quality Review completed on 11/15/04 by Steve Corya, Surveyor Supervisor. This visit was for a post survey revisit to the recertification and state licensure survey completed on 9/24/04. Dates of Survey: 10/8/9/10/ and 15 of 2004 Facility Number: 000659 Provider Number: 15G122 AIM :100272180 Surveyor: Mark Fisher, Medical Surveyor III Madison State Hospital was found to be in compliance in regard to 42CFR , Part 483 Subpart I and in regard to 431 IAC 1.1 in regard to the post certification revisit to the recertification and state licensure survey.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

L:\Provider Enroll\Letters\ISDH and Vendor Letters\RECERTN.DOC

Copy original mailed 11/6/01

October 31, 2001

Madison State Hospital
711 Green Rd
Madison, IN 47250

Re: Annual.Recertification:
Provider Number: 100272180
Madison State Hospital
711 Green Rd
Madison, IN 47250

Period of Certification: 12/01/01-11/30/02
Certified Beds: 47

Dear Provider:

EDS Provider Enrollment has been notified by the Indiana State Department of Health, the State survey agency, that the annual recertification of the above facility as a provider of services for the Developmentally Disabled in a Community Residential Facility under the Social Security Act, Title XIX, Section 1905, as amended, has been approved for the dates shown above.

In order for this facility to receive Medicaid payments during the above certification period, federal law requires that a provider agreement between The Office of Medicaid Policy and Planning (OMPP) and the Provider be in effect. One (1) copy of the Indiana Medicaid Provider Agreement is enclosed. The copy should be completed as outlined below:

1. The Federal ID number shall be entered in the space provided at the bottom of page four (4),
2. The owner, partner, or corporate officer with legal capacity to bind the provider business entity shall sign and date the copy on page 4 and;
3. Please retain a copy for your files, and mail the original to:

EDS
Indiana Medical Assistance Programs

P. O. Box 7263
Indianapolis, Indiana 46207-7263
Attention: Provider Enrollment

Unless such agreement is completed, no Medicaid reimbursement can be made. Execution of the Medicaid Provider Agreement completes the Medicaid provider recertification process.

Your continued cooperation and assistance in providing quality health care to Medicaid recipients is appreciated.

Sincerely,
EDS Provider Enrollment

cc: Myers and Stauffer LC
Mary Elsbury, EDS
Provider File

100272180

Office of Medicaid Policy and Planning, Office of the Children's Health Insurance Program

MEDICAID/CHILDREN'S HEALTH INSURANCE PROGRAM PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide Medicaid-covered and Children's Health Insurance Program (CHIP)-covered services and/or supplies to Indiana Medicaid and Indiana CHIP members. As a condition of enrollment, Provider agrees to the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("IFSSA").

2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program or CHIP, as they may be amended from time to time.

3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.

4. To notify IFSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.

5. To provide Medicaid-covered and CHIP-covered services and/or supplies for which federal financial participation is available for Medicaid and CHIP members pursuant to all applicable federal and state statutes and regulations.

6. To safeguard information about Medicaid and CHIP members including at a minimum:
   - a. members' name, address, and social and economic circumstances;
   - b. medical services provided to members;
   - c. members' medical data, including diagnosis and past history of disease or disability;
   - d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   - e. any information received in connection with the identification of legally liable third party resources.

7. To release information about Medicaid and CHIP members only to the IFSSA or its agent and only when in connection with:
   - a. providing services for members; and
   - b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid-covered and CHIP-covered services.

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.

9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered and CHIP-covered services rendered pursuant to this Agreement.

10. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436.*

11. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.

12. To submit timely billing on Medicaid and CHIP approved claim forms, as outlined in the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

13. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

14. To submit claim(s) for Medicaid or CHIP reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.

15. To submit claim(s) for Medicaid or CHIP reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.

16. To submit claims that can be documented by Provider as being strictly for:
- a. medically necessary medical assistance services;
- b. medical assistance services actually provided to the person in whose name the claim is being made; and
- c. compensation that Provider is legally entitled to receive.

17. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients.) Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.

18. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

19. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program and CHIP withheld, within sixty (60) days of receipt of notice from IFSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.

20. To pay interest on overpayments in accordance with *IC 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3.*

21. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid Program or CHIP.

22. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

23. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid and CHIP payments made to Provider, to assure the proper administration of the Medicaid Program and CHIP, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the Indiana Health Coverage Programs Provider Manual, and shall include, without being limited to, the following:
- a. medical records as specified by *Section 1902(a)(27)* of Title XIX of the Social Security Act, and any amendments thereto;
- b. records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;

- c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program or Indiana CHIP;
- d. documentation in each patient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;
- e. financial records maintained in the standard, specified form;
- f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.

24. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid program or CHIP.

25. To promptly correct deficiencies in Provider's operations upon request by IFSSA or its fiscal agent.

26. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
- a. the petitioner is a person to whom the order is specifically directed;
- b. the petitioner is aggrieved or adversely affected by the order;
- c. the petitioner is entitled to review under the law.

27. Provider must file a statement of issues within the time limits listed below, setting out in detail:
- a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
- b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

28. Time limits for filing an appeal and the statement of issues are as follows:
- a. A hospital licensed under *IC16-21* must file an appeal of any of the following actions within one hundred eighty (180) days of receipt of IFSSA's determination:
- (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
- (2) A notice of overpayment.
- (3)The statement if issues must be filed with the request for appeal.
- b. Other providers must file an appeal of determination that an overpayment has occurred within 60 days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
- c. All appeals of actions not described in (a) or (b) must be filed within 15 days of receipt of IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.

29. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

30. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a Medicaid-covered or CHIP-covered service.

31. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, or its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to," "mail to,",or home office), federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

32. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through D to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

Joseph E. Kernan
Governor

Gregory A. Wilson, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

COPY

RECEIVED
JAN 26 2004
MADISON STATE HOSPITAL
MADISON, IN 47250

NIKKI MORRELL
MADISON STATE HOSPITAL
711 GREEN RD
MADISON IN 47250-2199

RE: 711 GREEN RD
15G122

January 22, 2004

Dear NIKKI MORRELL:

A survey was conducted at your facility by the Division of Long Term Care, Indiana State Department of Health, to determine if your facility was in compliance with Federal requirements for nursing facilities on January 16, 2004. This survey found your facility to be in substantial compliance with the requirements of participation described in 42, Part 483 Subpart D and 431 IAC 1.1.

You will find enclosed a CMS Form 2567L showing that no state or federal deficiencies were cited. You may keep this form for your records.

If you have any questions concerning the instructions contained in this letter, please contact:

STEPHEN L UPCHURCH
ENFORCEMENT MANAGER
DIVISION OF LONG TERM CARE
INDIANA STATE DEPARTMENT OF HEALTH
2 N. MERIDIAN ST., SECTION 4B
INDIANAPOLIS, IN 46204-3003
317/233-7613 FAX: 317/233-7322

Sincerely,

Suzanne Hornstein

SUZANNE HORNSTEIN, Director
Long Term Care

cc: Supervisor
Public File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G122	A. BUILDING _____ B. WING _____	R 1/16/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{W 000}	INITIAL COMMENTS This visit was to conduct a post-certification revisit (PCR) survey to the PCR survey completed on 11/20/03 to the extended annual recertification and state licensure survey completed on 9/4/03. Dates of Survey: 1/15 and 1/16/04 Surveyor: Paula Chika Medical Surveyor III, Working Leader Facility Number: 000659 AIMS Number: 100272180 Provider Number: 15G122 Madison State Hospital was found to be in compliance with 42 CFR Part 483, Subpart I in regard to the PCR to the PCR of the recertification and state licensure survey. Quality Review completed 1-21-04 by C. Neary, Program Coordinator.	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards ovide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of rrection is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the cility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Frank L. O'Bannon
Governor

Gregory A. Wilson, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

Rec'd 10-4-02
cc: D. Woodfill
Original: S. Barnes

October 2, 2002

Steven Covington
Madison State Hospital
711 Green Road
Madison, Indiana 47250-2199

Dear Steven Covington:

On September 24, 2002, a Life Safety Code Annual Survey was conducted at your facility by the Division of Long Term Care, Indiana State Department of Health. This survey found your facility to be in substantial compliance.

You will find enclosed a HCFA Form 2567L showing that no state or federal deficiencies were cited. **Please keep this copy for your records.**

Sincerely,

Richard Powers

Richard Powers
Life Safety Code Supervisor
AC 317/233-7711

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G122	A. BUILDING 01 - BLDG B. WING _____	9/24/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON STATE HOSPITAL	711 GREEN RD MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	LIFE SAFETY CODE 1985 (RESIDENTAL B&C)	K 000		

This visit was for a Life Safety Code Recertification Survey.

Survey Date: 09/24/02

Provider Number: 15G122
AIM Number: 100272180
Facility Number: 000659

Surveyor: Mark Bugni, Life Safety Code Specialist

The facility, which consisted of building #34, a two story sprinklered building with a basement of Type I (332) construction, was in compliance with NFPA (National Fire Protection Association) 101, Life Safety Code (LSC) 1981 Edition, Chapter 13, Existing Health Care Occupancies.

(Clients were housed on the first floor only.)

Quality Review by Gerald C. Seifert, Life Safety Code Specialist - Medical Surveyor on 10/1/02.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

Robert Kunkel, M.D., is a consultant for the Center for Medicaid and State Operations Branch (CMS) formerly the Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. As a representative of the Federal Government, Dr. Kunkel will conduct a survey of Madison State Hospital, 711 Green Road, Madison, IN, February 25-27, 2002. The surveyor's Federal Identification Number is **17074**. This J-accredited, 80 bed, public facility was last surveyed October 29-31, 1997. The Provider Number for this facility is 15-4019. This will be a Recertification survey. If there are any concerns regarding this representative, you may direct your inquiry to:

Ms. Shirley Eldridge or Ms. Janice Graham
Co-Project Officers
Center for Medicaid and State Operations (CMS)
(410) 786-6836 and (410) 786-8020 respectively

or

Mr. Ted Feaster, Mr. Doug Wolfe and Ms. Nadine Renbarger
Regional Representatives - CMS Region V
(312) 353-4711, (312) 886-5214 and (312) 353-2850 respectively

Sincerely,

Janice Graham
Co-Project Officer
CMSO, Survey and Certification Group
Continuing Care Providers Branch